



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER, Governor  
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
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September 21, 2007

Michelle Tomlinson, Administrator  
Good Samaritan Assisted Living  
840 E Elva Street  
Idaho Falls, ID 83401-2899

Dear Ms. Tomlinson:

On September 12, 2007, a Fire Life Safety Survey was conducted at Good Samaritan Assisted Living. The facility was found to be providing a safe environment for its residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "Debbie Ransom for". The signature is written in a cursive, flowing style.

MARK GRIMES  
Supervisor  
Facility Fire Safety & Construction Program

MG/lj

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13RW7056</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>840 E ELVA ST IDAHO FALLS, ID 83401</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>Initial Comments</b></p> <p>The facility was found to be in substantial compliance with the fire and life safety requirements of the Rules for Residential or Assisted Living Facilities in Idaho. No core deficiencies were cited during the standard fire/life safety survey conducted on September 12, 2007.</p> <p>The surveyor conducting the survey was:</p> <p>Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety &amp; Construction Program</p>	R 000		

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

SQ3121

If continuation sheet 1 of 1